Summary of the Meeting
Maryland State Cardiac Data Advisory Committee
Maryland Health Care Commission

March 9, 2010

Members Present

Gary D. Walford, M.D., Chairman
Johannes Bonatti, M.D.
Nancy L. Bruce, R.N.
Anuj Gupta, M.D.
Deborah Harper, R.N.
Edward Kasper, M.D.
Roy Leiboff, M.D.
Roger Leonard, M.D.
Cheryl Lunnen, R.N.
Lisa Myers, R.N.
Michelle Pieffer, R.N.
Sharon Sanders, R.N.
Mark A. Turco, M.D.
Renee Webster
Jeffrey Wieland, M.D. (via conference call)

Others Present

Julie Blackburn, Anne Arundel Medical Center
Pat Cameron, MedStar Health
Ben Paul, Adventist HealthCare, Inc.
Wayne Powell, Society for Cardiovascular Angiography Intervention, Inc.
Gail Shults, Shady Grove Adventist Hospital

Commission Staff Present

Pam Barclay
Kendall Kodey
Theressa Lee
Scharmaine Robinson
Judith Wright

1. Call to Order

Gary Walford, M.D., Chairman of the Advisory Committee called the meeting to order at 5:00 p.m. and asked for a motion to approve the minutes from the December 14th, 2011 meeting. The minutes were unanimously approved as presented. Dr. Walford also introduced first guest speaker, Dr. Frederic S. Resnic, Director of the Cardiac Catheterization Laboratory at the Brigham and Women's Hospital and Harvard Medical School. Dr. Walford also noted that the representatives from NCDR would be joining the call later for the second presentation.

2. Presentation: MA Experience in Establishing a Statewide Cardiac Database

Dr. Resnic began with an outline of his presentation including a review of the Massachusetts experience with public reporting of cardiac data; the challenges associated with risk adjusted outcomes; the unintended consequences of public reporting; and the value of partnerships between clinicians and public health stakeholders.

He reported that the Massachusetts Department of Public Health (DPH) mandated clinical outcome registries in 2002 to monitor the performance of hospitals and doctors. He presented statistics on the number of Massachusetts residents undergoing invasive cardiac procedures and discussed the types of clinical datasets used to create the public reports. The organizations collaborating in the process included the DPH which regulates the policies associated with the process, Mass-DAC, the coordinating analytical center (which is funded through hospital fees based on volume), and MA-ACC which serves as the voice of the cardiology community.

He indicated that the CathPCI registry was chosen as the data source as it was considered a high quality clinical dataset. He also noted that here has been no evidence or validation for the use of administrative claims data. He added that the CathPCI registry was recommended by the 2001 advisory panel as the "best available" and over time it has been determined that additional clinical data is required for adequate risk adjustment and reporting. He discussed the mechanics of the process noting quarterly submissions to the CathPCI registry, reformatting requirements to analyze and link records, data quality review and the need for adjudication by physician volunteers for critical covariates and outcomes, compassionate use cases, and exceptional risk cases. He estimated that close to 200 hours of volunteer time was needed to get to publication.

Dr. Resnic reviewed the various reports in detail. A standardized mortality incidence rate (SMIR) was used to compare in-hospital risk-adjusted all-cause mortality as the measure for overall quality. No hospital to hospital comparisons were made, only hospital to state comparisons.

With respect to overall quality of care, the analysis should include four components - clinical outcomes, process measures, access to healthcare, and appropriateness. He noted that currently, they are focused on clinical outcomes. Unfortunately, you can have unexpected outcomes in other areas when only focusing on one component, such as risk avoidance.

Dr. Resnic noted the challenges associated with appropriateness of care and case selection creep. He reviewed slides that analyzed the relationship between patient benefit (both actual and perceived) and the chance of patient survival. The cases being skipped are the times when the benefit to the patient is great but the rate of survival is low. This is where the relative cost of revascularization is actually the highest. He cautioned the group that public reporting can create perverse incentives associated with decisions regarding patient treatment. Massachusetts has tried to address these challenges, in part, by implementing a policy of 100% adjudication of compassionate use cases and by incorporating an appeal process. Compassionate use is defined as patient in a coma on presentation, a requirement for percutaneous assist support or bypass, or

CPR at start of procedure. This has created improvement in mortality prediction modeling and doctors see this as an appropriate adjustment for the care of these sicker patients.

The success of this project is due to its reliance on high quality, granular clinical data, hierarchical modeling to address inter-institutional variability and collaboration with clinical representatives. Dr. Resnic reiterated the need to address appropriateness of care. One strategy would be to implement a rigorous approach of comprehensive case review with abstraction of appropriate use data for each case. This would be very costly. Alternatively, a hybrid approach would involve screening a sample of a provider's cases for review by an independent physician panel and comprehensive review of all negative outliers by the independent panel. Massachusetts is considering the hybrid approach.

Following the presentation, several committee members asked questions of Dr. Resnic. Dr. Turco expressed concern about the use of administrative data for public reporting of cardiac information. Dr. Resnic explained that the clinical data was the primary data source for Massachusetts reporting, but administrative data could be supplemented for a useful blended dataset for longer term outcomes analysis. Dr. Walford asked for more information on the process for obtaining physician volunteers. Dr. Resnic responded that the process involves a little 'arm twisting', but physicians recognize that they must be active participants in the process. They have about 25 physician volunteers who participate in 6-8 case review sessions. Audited cases include all high risk PCIs, deaths, and compassionate use cases, and a random sampling of non-risk cases. Dr. Leonard asked about the cost of the program? Dr. Resnic responded that the the entire budget is around $300,000 a year. The Mass-DAC budget is subsidized by the hospitals. Brigham and Women's Hospital contributes about $25,000 a year. The public health portion is much smaller.

Dr. Walford asked for Dr.Resnic's overall impression of public reporting. Dr. Resnic responded that there is value to public reporting and there are tradeoffs. Increasing transparency and gaining the public trust are important. Often, the clinicians think they are being treated unfairly and the regulators think the treatment is too easy. Most don't think the right balance has been struck. Dr. Turco added that we need to monitor the appropriateness of procedures and that is as important if not more so than outcomes based reporting. To deal with risk aversion, why didn't you focus on in-hospital mortality rather than all-cause mortality? Dr. Resnic responded that he and the other physicians argued for cardiac mortality but ultimately the leadership argued that it is too subjective to be valid.

3. Presentation: Quality Checks used by NCDR ACTION & CathPCI Registries

Sue Rogers, RN, MSN, Program Director ACTION Registry-GWTG, Tony Herman, RN, MSN Program Director, CathPCI Registry and Kim Hustler RN, Clinical Quality Consultant ACTION Registry-GWTG joined the meeting via conference call. Kim Hustler provided a detailed review of the data quality review processes and reports that are incorporated in the ACTION Registry. She noted that hospitals must pass the quality reports to successfully submit data. Tony Herman added that the CathPCI registry process was very similar and noted that some of the metrics have

different thresholds due to different circumstances. There is an audit component that includes the review of both PCI and ACTION cases targeted through random case selection and the identification of outliers. Dr. Walford asked for an estimate of the costs associated with the audit? Ms. Rogers responded that it depends on the number of hospitals to be audited. NCDR would contract with the third party vendor on the state's behalf. An estimate of $150,000 - $200,000 for the whole state was given.

Following the two presentations, the committee discussed next steps. Dr. Walford noted that it is beneficial to know what other states are doing as Maryland will have to consider similar issues. Maryland could establish an approach similar to Massachusetts in getting physician volunteers to audit other hospitals. It would be good to get more information on the third party contractor (West Virginia) that performs the auditing for NCDR as well as the adjudication and appeal processes. In terms of public reporting, the committee should consider reporting facility specific only or physician and facility specific data. Although we will be leading the way with the ACTION registry, it is best to learn from the other states on their CathPCI experience. Pam Barclay mentioned that she is working to arrange a presentation from New York for the next advisory committee meeting.

4. Other Business

There was no other business for discussion.

5. Adjournment and Scheduling of Next Meeting Date

The Committee agreed to meet on the second Wednesday of the month at 5:00 p.m. The meeting adjourned at 7:00 p.m.